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W 000	INITIAL COMMENTS A recertification survey was conducted from January 4, 2010, through January 6, 2010. The survey was initiated using the fundamental survey process. A random sample of two clients was selected from a client population of three males with various disabilities. The findings of the survey were based on observations in the home and one day program, interviews with staff in the home and at the day program, as well as a review of the clinical, administrative, and habilitation records; including a review of the unusual incident/investigation reports.	W 000	Symbral has received a copy of deficiency report for survey was conducted. We have formulated a QA Team with monitoring tools developed and implemented to ensure that diagnostic, curative and preventative interventions are conducted in a timely manner to ensure compliance.	2/28/10 and ongoing
W 159	483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional. This STANDARD is not met as evidenced by: Based on observation, staff interview, and record review, the facility failed to ensure the Qualified Mental Retardation Professional (QMRP) coordinated, integrated and monitored services, for three of the three clients residing in the facility. (Clients #1, #2, and #3) The findings include: 1. The facility's QMRP failed to coordinate services with the day program to address Client #2's behavioral needs as evidenced below: Interview with Client #2's day program (DP) case manager on January 6, 2010, at 12:40 p.m.	W 159	Received 3/1/10 GOVERNMENT OF THE DISTRICT OF COLUMBIA DEPARTMENT OF HEALTH HEALTH REGULATION ADMINISTRATION 825 NORTH CAPITOL ST., N.E., 2ND FLOOR WASHINGTON, D.C. 20002	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: CFO | (X6) DATE: 2-26-10

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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W 159	Continued From page 1 revealed that the client exhibited a behavior of attempting to touch food and/or drink belonging to others. Client #2's DP First Quarterly Report (for August, September, October 2009) dated November 30, 2009, revealed the client continued to have issues with touching food and beverages belonging to others at both the day program and in the community. The quarterly report further stated that "He refuses his food most of the time, except when he is taken out to eat." The case manager stated that the day program psychologist would be requested to assess the client and develop proactive strategies to prevent the aforementioned behavior. Further discussion with the case manager indicated that the day program did not have a copy of the behavior support plan (dated August 21, 2009) or the Individual support plan (dated August 7, 2009) which were being implemented at the group home. Interview with the QMRP on January 6, 2010, at approximately 3:15 p.m. confirmed Client #1 had a behavior support plan (BSP) dated August 21, 2009, which was being implemented at the group home. The QMRP indicated that the ISP (including the BSP) is provided to the day program by the government service coordinator. Record review on January 6, 2010, at 3:25 p.m. revealed Client #2's BSP required that he was monitored for several targeted behaviors, one of which was "Inappropriate touching". (touching others, putting hands in pants, and smelling others), Further review of the BSP revealed, however, that it did not identify attempting to touch food and/or drink belonging to others as a targeted behavior. There was no evidence that services had ben coordinated to ensure that	W 159	Targeted behaviors as per psychologist report are identified and discussed at ISP Meeting. Day Program Coordinators attend these meetings as such they are aware of such behaviors. DDS Service Coordinator faxed copy of individual #2 ISP which includes copy of BSP to NCC on 2/26/10. Confirmation of faxed documents was forwarded to QMRP by DDS Service Coordinator. The individual's BSP addresses inappropriate touching which includes touching of food and drink belonging to others.	2/26/10 and ongoing

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W 159	Continued From page 2 Client #2's attempting to touch food and/or drink belonging to others was being effectively addressed. 2. The facility's QMRP failed to ensure that staff were effectively trained on documentation of topical treatments. (See W368) 3. The facility's QMRP failed to ensure an effective system was implemented to monitor Client #1's tolerance of his recommended eyeglasses. (See W436) 4. The facility's QMRP failed to coordinate services to ensure direct care staff received training on how to operate Client #3's low-tech (Basic Talk 4) AAC device. (See W189) 5. The QMRP failed to coordinate services to ensure Client #3 received training timely to address his communication needs. (See W249) 6. The QMRP failed to coordinate services to ensure comprehensive nutritional reassessments for Clients #1 and #2. (See W217)	W 159	LPN Case Manager conducted training on documentation of topical on 1/9/10. Monitoring tool for wearing of eye glasses was developed on 1/6/10 and staff training effected on 1/6/10 and 1/7/10. Speech and Language Therapist conducted training on utilization of communication device on 1/10/10. QMRP documented efforts to obtain adaptive equipment to address individual #3 communication needs. A letter was sent to Speech and Language Therapist requesting that once Augmentative device is recommended as per Speech and Language assessment within 30 days of assessment in conjunction with necessary staff training to facilitate implementation of goal as identified by ISP Team.	1/14/10 and ongoing 1/6/10 and ongoing 1/10/10 and ongoing 1/26/10 and ongoing
W 189	483.430(e)(1) STAFF TRAINING PROGRAM The facility must provide each employee with initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure initial and continuing training that enabled each staff to effectively and competently perform their duties for one of three clients in the survey. (Client #3)	W 189		

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W 189	Continued From page 3 The finding includes: [Cross refer to W436] Observations during the survey revealed that Client #3 did not use his "low-tech (Basic Talk 4) AAC device." Interview with the Qualified Mental Retardation Professional (QMRP) on January 5, 2010, at 9:39 a.m. revealed that the device was not being used by the client because staff had not been trained on how to use it. Further interview with the QMRP on January 5, 2010, at approximately 10:39 a.m. revealed the training had been initially scheduled for December 16, 2009, however had been rescheduled by the SLP for January 9, 2010. At the time of the survey, there was no evidence the facility had ensured training timely to the staff on how to operate Client #3's "low-tech (Basic Talk 4) AAC device."	W 189		
W 217	483.440(c)(3)(v) INDIVIDUAL PROGRAM PLAN The comprehensive functional assessment must include nutritional status. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure a comprehensive assessment of the nutritional needs of two of two clients in the sample. (Clients #1 and #2) The findings include 1. The facility failed to ensure a comprehensive reassessment of Client #2 ' s food preferences and the continued need for a nutritional supplement as evidenced below:	W 217		

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W 217	Continued From page 4	W 217		

On January 4, 2010 at 6:05 p.m., Client #2 received his dinner meal (fish, yellow rice, green beans, pear halves) and 8 ounces of Resource " Breeze " . He drank all of the Resource " Breeze " , however required verbal prompts from staff to eat his meal. At 6:38 p.m., approximately thirty minutes later, staff asked him if he was finished eating, and the client gently slapped his own face. He went to the kitchen at 6:44 p.m. and raked approximately 60% of his fish, yellow rice, green beans from the plate into the trash can, but ate most of the fruit.

Several minutes later (6:50 p.m.), the licensed practical nurse (LPN) indicated that if the client was finished eating, he would normally take his plate to the kitchen. Staff indicated that the client sometimes refused his food, however usually drank 100% of his beverages and ate his dessert. Interview with the staff preparing the meal revealed the client was prescribed a regular high fiber diet and 8 ounces Resource " Breeze ", one time daily. According to staff, the client would be offered a snack later that evening.

During the day program visit on January 6, 2010, at 12:30 p.m., interview with the day program nurse revealed that staff had reported that Client #2 was a " picky eater and usually ate his snack, but often put his sandwiches in the trash.

On January 6, 2010, at 2:45 p.m., a nursing progress note dated August 18, 2009, revealed the nurse's attempts to reach the nutritionist to discuss the possibility of discontinuing the nutritional supplement because Client #2 was eating 100% of his meals. On January 6, 2010, at 3:10 p.m., review of the client ' s nutritional

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W 217	Continued From page 5 assessments at the group home revealed the client's food intake was " usually 75%-100% ". The client's health management care plan dated August 7, 2009, revealed a goal to consume 100% of his food. On January 6, 2010, at 10:33 a.m., review of the annual nutrition assessment dated July 10, 2009, revealed Client #2 "tolerates consistency. Can be picky at times. Staff says appetite has improved. Likes things like hamburgers, fries milk and peanut butter, and jelly sandwiches. Appetite is 75-100%....estimated kcal needs -1731. " A nutrition quarterly report dated October 24, 2009, documented that the client's regular diet provided 2000 to 2400 calories. At the time of the survey, however, there was no evidence that Client #2 had been reassessed to determine if offering him more of the preferred foods would maximize intake of the foods in his diet. 2. The facility failed to ensure that Client #1 caloric needs for weight gain within his desirable weight range were reassessed as evidenced below: During dinner observations on January 4, 2010, at 6:05 p.m., Client #1 slowly ate 100% of a double portion meal and drank 8 ounces of Ensure Plus. He completed his meal at 6:54 p.m., approximately 50 minutes later. Interview with staff during the dinner meal revealed the client enjoys his double portions and always consumed 100% of his meals and supplement. Further observation of the client, however, revealed he appeared to be underweight for his height.	W 217	A letter was sent to Nutritionist on 2/26/10 that a reassessment be done for individual #2 to determine if offering him more food of his preferences will maximize intake of diet at meal times copies of letter were sent to Day Program, Social Worker and DDS Service Coordinators follow up response was also be forwarded to ensure best service to individual. QMRP, RN, DON and House Manager will monitor for compliance.	3/10/10 and ongoing

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W 217	Continued From page 6 Interview on January 4, 2010, at 6:17 p.m. revealed the client was prescribed a low fat, low cholesterol, chopped, no concentrated diet (double portion for breakfast and dinner) and a p.m. snack. Staff reported that the client was also prescribed a supplement of Ensure Plus (8 ounces) three times daily to help him gain weight. Interview with the day program staff on January 5, 2010, at 12:35 p.m. revealed that the Client #1 was prescribed single portions at lunch and a morning and afternoon snack. During the day program visit, the client was observed to consume 100% of a single portion diet. During the survey, staff at the day program and the group home agreed that the client usually consumed 100% of the food and beverages offered. The review of the weight records on January 5, 2010, at 2:15 p.m. revealed the client had a recommended weight range of 135 to 167 pounds. Further review of the weight chart revealed Client #1 ' s fluctuating weight from January 2009 (135 pounds) to December 2009 to (133 pounds). On January 6, 2010, at 2:37 p.m., the quarterly nutritional assessment dated October 24, 2009, revealed "Current diet provides 3000 - 3500 calories." The assessment documented that the consumed approximately 75 to 100% of his diet and tolerated his diet well. Although the annual and quarterly nutritional assessments continued to identify weight gain as a goal, the client achieved no net weight gain from January 2009 to December 2009. At the time of the survey, there was no evidence that the client's caloric need to promote weight had been reassessed by the nutritionist and the interdisciplinary team. (See also W322.2)	W 217		
W 249	483.440(d)(1) PROGRAM IMPLEMENTATION	W 249		

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W 249	Continued From page 7 As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan. This STANDARD is not met as evidenced by: Based on observation, Interview and record review, the facility failed to ensure continuous active treatment was provided as recommended by the interdisciplinary team (IDT) to address the communication needs for one of the three clients residing in the facility. (Client #3) The finding includes: [Cross refer to W436) During the evening observations on January 4, 2010, at 5:40 p.m., Client #3 was observed responding to staff using short and echolaic sentences. Interview with staff revealed that Client #3 had a communication device, however was not using it because staff had not been trained on how to use it. Record review on January 5, 2010, at 10:45 a.m., revealed a Speech and Language assessment dated January 31, 2009, documented the client ' s weaknesses as reduced manual dexterity and a short attention span. A training objective (dated April 8, 2009), using the Basic Talk AAC device was scheduled to be implemented on May 8, 2009. The goal was " to increase communication skills with the use of a low tech electronic AAC	W 249	Crossed referenced and adopted with W159.4 and W159.5. Crossed referenced and adopted with W159.4, W159.5, W189 and W249.	1/26/10 and ongoing 1/10/10 and ongoing

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W 249	Continued From page 8 device. " Stated training objectives were designed to enable the client to make requests, to state his name on request, to answer simple questions and to state identifying information. Interview with the QMRP on January 5, 2010, at 9:39 a.m., revealed that the IDT approved the communication goal and that it was to be implement after Client #3 ' s individual support plan (ISP) which was conducted on April, 8, 2009. Further interview with the QMRP revealed the AAC device was not received until November 2009 that currently staff was awaiting training on how to use the device. On January 5, 2010, at 10:45 a.m., the review of a QMRP note dated June 12, 2009, revealed the AAC device had not been delivered. "Program on hold until delivery of AAC device". Subsequent QMRP progress notes dated July 12, 2009, August 20, 2009, and October 26, 2009 also revealed the AAC device was not available to implement the training objective. At the time of the survey, there was no evidence that the facility had ensured that Client #3 received continuous active treatment to improve his communication skills.	W 249	Crossed referenced and adopted with W189.	1/26/10 and ongoing
W 322	483.460(a)(3) PHYSICIAN SERVICES The facility must provide or obtain preventive and general medical care. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure preventive health services were implemented as recommended for one of two clients in the	W 322		

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W 322	Continued From page 9 sample. (Client #1) The findings include: 1. The facility failed to ensure that Client #1 caloric needs for weight gain to within his desirable weight range were reassessed. During dinner observations on January 4, 2010, at 6:05 p.m., Client #1 slowly ate 100% of a double portion meal and drank 8 ounces of Ensure Plus. He completed his meal at 6:54 p.m. approximately 50 minutes later. Interview with staff during the dinner meal revealed the client enjoys his double portions and always consumed 100% of his meals and supplement. Further observation of the client, however, revealed he appeared to be underweight for his height. Interview with the licensed practical nurse (LPN) on January 5, 2010 at approximately 11:35 p.m. revealed that Client #1's weight was being monitored by the nutritionist. Additionally, interview with the nurse revealed that health monitoring was conducted by the nursing staff, the primary care physician, and other medical consultants as needed for the client. Record review on January 5, 2010, at 12:10 p.m. revealed the client's most current weight was 133 pounds (December 2009) and that his desirable weight range (DWR) was 135 to 167 pounds. Continued record review revealed the client had no net weight gain during the last twelve months. At the time of the survey, the client's weight remained below his established desirable body weight. 2. Further record review on January 6, 2010,	W 322	Since survey period individual's weight is 138 lbs (DWR) 135-167 lbs hence individual is within DWR. In addition cross referenced and adopted with I401.1. Nutritional Assessment individual on 1/16/10 and diet to satisfy caloric need.	1/16/10 and ongoing

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W 322	Continued From page 10 beginning at 3:40 p.m., revealed Client #1 had radiologic monitoring as evidenced below: a. December 22, 2008 - CT Scan - (Results) (1) 9 mm geographic lytic lesion in the C6 vertebral body, which was not within the field of view on the prior examination. (2) Region of focal lucency in the sternum at the level of the first costosternal articulation. While this finding is more conspicuous than on the prior examination, it has internal fat density. Further review of the report of the study on the aforementioned date revealed the most concerning finding was the cervical vertebral body lesion. "The appearance of the scapular lesion suggests that it may not be related to the vertebral body lesion. The vertebral body lesion raises the concern for metastatic disease and myeloma, and recommends further evaluation with nuclear medicine bone scan and myeloma labs." b. December 31, 2008 - Radiologic examination for further assessment of the "Vertebrae Lesions (back)", (Results) (1) The finding in the right glenoid may represent arthritic/degenerative change, however, the primary bone lesion is also considered. (2) Recommend radiographic correlation of the right glenoid." c. February 11, 2009 - Recall visit for a MRI of Right Scapula to evaluate the scapula lesion. A consultation report revealed a recall visit for a MRI of Right Scapula to evaluate the scapula lesion. The consultation report noted the following information:	W 322	PCP in reviewing result of CT scan recommended further evaluation of lab done on 12/29/08 which ruled out Multiple Myeloma.(see attached) A bone scan evaluation was done on 12/31/08 as recommended (see attached). PCP Findings of all diagnostic and laboratory tests were communicated to the PCP who did not recommend a repeat MRI with sedation, but referred to an Oncologist for further evaluation. (see attached) Nursing team has scheduled appointment for individual #1 and will ensure appropriate follow up will take place. Ongoing monitoring will be performed by Nursing team to ensure compliance.	12/29/08 and ongoing 2/28/10 and ongoing

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W 322	Continued From page 11 (1)"Findings of the February 11, 2009, partial study revealed a "Comparison with prior MRI of August 7, 2008 and CT of December 22, 2008. (2) C6 and sternal lesions discussed on the December 22, 2008, were not within the field of the examination. "Unable to do study due to the fact that patient was moving during study. Patient needs sedation." (3) Examination was not performed for the evaluation of the rotator cuff or glenoid labrum. d. February 27, 2009 - Recall visit for a MRI of Right Scapula to evaluate the lesion. (Results) The client was sedated with Alprazolam 3 mg PO at 2:00 p.m. The consultation report contained a comment, "Patient unable to hold still for MRI." Record review on January 6, 2010 , at 4:40 p.m., revealed a physician's order dated March 31, 2009, regarding the February 27, 2009, recall visit for MRI. The order revealed that due to two attempts, one with sedation and one without sedation, the MRI of Rt. Scapula should not be repeated. There was no evidence the facility had developed strategies for monitoring and/or alternatively addressing the abnormal findings described in the client's readiological studies.	W 322	Findings of all diagnostic and laboratory tests were communicated to the PCP who did not recommend a repeat MRI with sedation, but referred to an Oncologist for further evaluation. (see attached) Nursing team has scheduled appointment for individual #1 and will ensure appropriate follow up will take place. Ongoing monitoring will be performed by Nursing team to ensure compliance.	2/28/10 and ongoing
W 331	483.460(c) NURSING SERVICES The facility must provide clients with nursing services in accordance with their needs. This STANDARD is not met as evidenced by:	W 331		

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W 331	Continued From page 12 Based on interview and the record review, the facility's nursing services failed to ensure nursing services for one of two clients in the sample. (Client #1) The finding includes: The facility's nursing services failed to ensure that Client #1 received treatment with Selenium Sulfide 2.5% as prescribed to treat the rash behind his right ear/neck. (See W368)	W 331	LPN Case Manager has conducted training on documentation of topical on 1/14/10. A monitoring tool has been developed. House Manager will monitor documentation daily for the next 90 days. LPN Case Manager will monitor weekly and monthly for the next 90 days (3 months). RN, DON and QMRP will monitor quarterly to provide adherence.	2/1/10 and ongoing
W 356	483.460(g)(2) COMPREHENSIVE DENTAL TREATMENT The facility must ensure comprehensive dental treatment services that include dental care needed for relief of pain and infections, restoration of teeth, and maintenance of dental health. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure timely treatment services for the maintenance of dental health of one of two clients in the sample. (Client #2) The finding includes: Interview with the LPN on January 6, 2010, at 10:12 a.m. revealed that Client # 2 had regularly scheduled dental visits. On January 6, 2010, at 10:30 a.m., review of a dental consultation report dated April 13, 2009 revealed the purpose of the visit was to have two cavities filled. It was noted on the report, "Performed one surface composite filling on #11." The client returned to the dentist on October 28,	W 356	LPN Case Manager has scheduled dental evaluation for individual #2 for 3/10/10 to query if second cavity was filled. Symbral has increase nursing administrative staff, in the hiring of a RN for IC/MR facility with a specific job description of monitoring all medical consultation with concentration on recommendation, diagnosis and treatment provided. LPN Case Manager will monitor monthly, RN and DON will monitor monthly and provide quarterly oversight to ensure compliance.	3/10/10 and ongoing

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W 356	Continued From page 13 2009 and was non-compliant for treatment. Sedation was recommended for the next scheduled appointment. On January 6, 2010, at 3:35 p.m., the record review revealed that the client returned to the dentist on November 4, 2009. The consultation report, however, did not mention of the second cavity, which was identified by the dentist on April 13, 2009. Interview with the nurse on January 6, 2010, at 3:49 p.m. revealed it could not be confirmed if the second cavity had been filled. At the time of the survey, there was no evidence that the client had received the recommended preventive treatment for the maintenance of his dental health.	W 356		
W 368	483.460(k)(1) DRUG ADMINISTRATION The system for drug administration must assure that all drugs are administered in compliance with the physician's orders. This STANOARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure that all drugs were administered in compliance with the physician ' s orders for one of two clients in the sample. (Client #1) The finding includes: Interview with the licensed practical nurse (LPN) on January 5, 2010, at 3:46 p.m. revealed Client #1 that Selenium Sulfide 2.5% was prescribed to treat the rash behind his right ear/neck. Record review on January 5, 2010, at 4:03 p.m. revealed a physician's order dated October 19, 2009 for "Selenium Sulfide lotion 2.5%, apply to	W 368	Crossed referenced and adopted with W331.	2/10/10 and ongoing

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W 368	Continued From page 14 neck at bed time..." The LPN reported that upon receipt of the cream, the direct care staff were instructed on how and when to apply the medication, and to document each time it was applied. The review of the MAR, however, revealed no documented evidence that the cream was applied to the client's neck, as prescribed, from October 21, 2009 through October 31, 2009.	W 368	Crossed referenced and adopted with W159.2.	1/9/10 and ongoing
W 436	483.470(g)(2) SPACE AND EQUIPMENT The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure timely and effective training to encourage wearing of eyeglasses recommended by the interdisciplinary team for two of three clients residing in the facility. (Clients #1 and #3) The finding includes: Interview with the staff on January 4, 2010, at 4:50 p.m.revealed the client had eye glasses, but did not wear them. Continued interview with staff on January 6, 2010, at 3:50 p.m. revealed Client #1 required lots of encouragement to put his eye glasses on, and then refused to keep them on for longer than a minute. With encouragement from staff at approximately 5:15 p.m., the client put on his glasses and looked in the mirror, but refused to keep on the glasses. Staff indicated that the	W 436	Crossed referenced and adopted with W159.3, W159.4 and W189.	1/6/10 and ongoing

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W 436	Continued From page 15 client was offered his eyeglasses daily at the group home, however did not take them to his day program. Record review on January 6, 2010, at 4:20 p.m. revealed an ophthalmology report dated June 11, 2009, that revealed the client was diagnosed with hyperopia and that eye glasses were recommended. The individual support (ISP) dated August 3, 2009, included a recommendation that the client wear his prescribed eye glasses. Although the client was observed to have the prescribed eye glasses, there was no evidence a structured system had been implemented to increase the client's tolerance of his eye glasses recommended by the IDT to improve his vision. 2. The facility failed to ensure that Client #3 was timely provided a recommended augmentative communication device as evidenced below: Interview with staff on January 4, 2010, at 6:15 p.m., revealed that Client #3 had a "low-tech (Basic Talk 4) AAC device", however, was not using it because staff had not been trained on how to use it. At no time during the survey was the client observed to use his "low-tech (Basic Talk 4) AAC device ." Interview initiated with the Qualified Mental Retardation Professional (QMRP) on January 5, 2010, at 9:37 a.m., revealed that the Speech and Language Pathologist (SLP) was to order the communication device for the client during the first quarter of 2009. According the QMRP, the SLP had stated various reasons why the "low-tech (Basic Talk 4) AAC device " was not available. As a result of these delays, the client did not receive the low-tech (Basic Talk 4) AAC device until November 2009.	W 436	Crossed referenced and adopted with W159.5 and W189.	1/10/10 and ongoing

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W 436	Continued From page 16 On January 5, 2010, at approximately 10:15 a.m., the residential director (RD) presented a communication device which was observed to be a "low-tech (Basic Talk 4) AAC device ." The RD stated that the device belonged to Client #3. The subsequent record review on January 5, 2010, at 10:45 a.m. revealed the following timeline regarding the communication device: a. December 2, 2008: The court hearing report expressed concern that a previous SLP assessment, dated March 2007 indicated that the client was not a good candidate for a low or high tech augmentative communication device due to his physical limitations and congenital deficits. The court hearing report directed the QMRP to find a different speech/language evaluator, one who would recommend the utilization of computer vocabulary programs, one-on-one assistance and/or other possibilities to "expand horizons" of the client before his 2009 individual support plan (ISP) meeting. b. Record review on January 5, 2010, at 9:40 a.m. revealed a speech and language evaluation dated January 31, 2009. According to the assessment, the impression was that the client was likely to benefit from the use of an augmentative communication device to enhance his communicative abilities." The assessment recommended "Exploratory use of a low-tech (Basic Talk 4) AAC device ..." At the time of the survey, there was no evidence the facility had ensured that Client #3 timely received the low-tech (Basic Talk 4) AAC device recommended by the IDT to enhance his communication.	W 436	Court ordered assessment was done in a timely manner on 1/31/09 before individual's #3 ISP Meeting Crossed referenced and adopted with W189.	1/31/09 and ongoing 1/26/10 and ongoing

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I 000	INITIAL COMMENTS A licensure survey was conducted from January 4, 2010 through January 6, 2010. The survey was initiated using the fundamental survey process. A random sample of two residents was selected from a resident population of three males with various disabilities. The findings of the survey were based on observations in the home and one day programs, interviews with staff in the home and day programs, as well as a review of the clinical, administrative, and habilitation records; including a review of the unusual incident/investigation reports.	I 000	Symbral's governing body have established a QA team that will conduct weekly monitoring to ensure diagnostic, preventative and curative measures to maintain compliance relating to deficiencies identified.	2/28/10 and ongoing
I 090	3504.1 HOUSEKEEPING The interior and exterior of each GHMRP shall be maintained in a safe, clean, orderly, attractive, and sanitary manner and be free of accumulations of dirt, rubbish, and objectionable odors. This Statute is not met as evidenced by: Based on observation and interview, the GHMRP failed to maintain the exterior of the facility in a safe manner as evidenced: The finding includes: On January 5, 2010, at 8:20 a.m., the ramp at the edge of the driveway was observed to have a board which was breaking off on the right side. Interview with the staff revealed that major repairs had been performed on the ramp since the last survey. At the time of the survey, however, there was no evidence the aforementioned area of the ramp had been	I 090	As per maintenance policy. House Manager has issued maintenance engineer with a job order to effect repairs identified. Maintenance Engineer has completed repairs cited on 2/26/09. Symbral's QA Team, QMRP, House Manager and Maintenance Engineer will monitor to ensure compliance.	2/26/10 and ongoing

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I 090	Continued From page 1 maintained in good repair.	I 090		
I 206	3509.6 PERSONNEL POLICIES Each employee, prior to employment and annually thereafter, shall provide a physician ' s certification that a health inventory has been performed and that the employee ' s health status would allow him or her to perform the required duties. This Statute is not met as evidenced by: Based on interview and record review, the facility failed to ensure that each consultant had a health evaluation at least annually for three consultants (Consultants #1, #2 and #3). The finding includes: During the entrance conference on January 4, 2010, the Qualified Mental Retardation Professional (QMRP) was requested to provide health certificates for staff and consultants working with the individuals in the GHMRP. Interview with the QMRP revealed that the health certificates were at the administrative office and would be provided on January 5, 2010. On January 5, 2010, at 9:40 a.m., record review revealed health certificates had expired for Consultants #1, #2, and #3. It was noted that that Consultant #3 had a current tuberculin screening, however lacked a health certificate. At the time of the survey, there was no evidence the GHMRP ensured each consultant provided documentation to verify a current health certification had been performed.	I 206	Symbral's governing body has shifted responsibility of Auditing of consultants' file to job duties of the QMRP. A monitoring tool was developed that will be used to audit consultant's files quarterly. A follow up of 30 days notification letter will be issued to consultants. Follow telephone calls or written notification will be kept to allow QMRP to ensure compliance to this standard. Client #3 was sent written notification on 2/24/10 requesting that an annual physical be provided to QMRP in place of an annual T.B. screening.	2/28/10 and ongoing

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I 222	3510.3 STAFF TRAINING There shall be continuous, ongoing in-service training programs scheduled for all personnel. This Statute is not met as evidenced by: Based on observation, interview and record review, the GHMRP failed to provide ongoing training for all staff to effectively perform their duties for two of three residents in the facility. (Residents #1 and #3) The finding includes: 1. The GHMRP failed to ensure that staff were training on the use of Resident #3's Basic Talk 4 communication device as evidenced below: [Cross refer to Federal Deficiency Report - W436.2]. Observations during the survey revealed that Resident #3 did not use his "low-tech (Basic Talk 4) AAC device." Interview with the Qualified Mental Retardation Professional (QMRP) on January 5, 2010, at 9:39 a.m. revealed that the device was not being used by the resident because staff had not been trained on how to use it. Further interview with the QMRP on January 5, 2010, at approximately 10:39 a.m. revealed the training had been initially scheduled for December 16, 2009, however had been rescheduled by the Speech and Language Pathologist for January 9, 2010. At the time of the survey, there was no evidence the facility had ensured training timely to the staff on how to operate Resident #3's "low-tech (Basic Talk 4) AAC device." 2. Cross refer to Federal Deficiency Report -W368] The GHMRP failed to ensure staff was	I 222	Communication device was obtained and in place at time of the survey, however was not able to be implemented due to failure of Speech Therapist to provide in-service training to staff. There was documented evidence on file at the time of the survey of communications between QMRP and Speech Therapist to obtain same training. Training on individual #3's low-tech (Basic Talk 4) AAC device was done on 1/9/10 and the program was implemented on the same date. LPN Nurse Case Manager conducted training on consistent documentation of the application of topical medication.	1/9/10 and ongoing 1/14/10 and ongoing

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I 222	Continued From page 3 effectively trained to consistently document the application of topical medication for Resident #1.	I 222		
I 401	3520.3 PROFESSION SERVICES: GENERAL PROVISIONS Professional services shall include both diagnosis and evaluation, including identification of developmental levels and needs, treatment services, and services designed to prevent deterioration or further loss of function by the resident. This Statute is not met as evidenced by: Based on observation, interview and record review, the Group Home for the Mentally Retarded Persons (GHMRP) failed to ensure professional services were provided in accordance with the needs of three of three residents in the GHMRP. (Residents.# 1, #2, and#3) The findings include: 1. The GHMRP failed to ensure preventive health services were implemented for one Resident #1 as evidenced below: During dinner observations on January 4, 2010, at 6:05 p.m., Resident #1 slowly ate 100% of a double portion meal and drank 8 ounces of Ensure Plus. He completed his meal at 6:54 p.m. approximately 50 minutes later. Interview with staff during the dinner meal revealed the resident enjoys his double portions and always consumed 100% of his meals and supplement. Further observation of the resident, however, revealed he appeared to be underweight for his height. Interview with the licensed practical nurse (LPN)	I 401	Record of vital signs and weight monitoring indicates that individual started to experience notable decline in weight status in Feb. 2007. At which point a Nutritional assessment was conducted and a change in diet reflecting double portions breakfast and dinner, soft sandwich at pm snack and supplement added. Since dietary change individual has shown a weight gain of 20 lbs and over. He has also maintained this weight with a fluctuation of 1 or 2 lbs. Since survey period individual's weight has been reassessed and found to be within DWR gaining 5 lbs. During the period of weight decline several medical diagnostic and laboratory tests were done to determine the etiology for decline in weight. Currently further evaluation by specialty physicians, is being conducted until a resolution is found.	2/28/10 and ongoing

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I 401	Continued From page 4 on January 5, 2010 at approximately 11:35 p.m. revealed that Resident #1's weight was being monitored by the nutritionist. Additionally, interview with the nurse revealed that health monitoring was conducted by the nursing staff, the primary care physician, and other medical consultants as needed for the resident. Record review on January 5, 2010, at 12:10 p.m. revealed the resident's most current weight was 133 pounds (December 2009) and that his desirable weight range (DWR) was 135 to 167 pounds. Continued record review revealed the resident had no net weight gain during the last twelve months. At the time of the survey, the resident's weight remained below his established desirable body weight. 2. Further record review on January 6, 2010, beginning at 3:40 p.m., revealed Resident #1 had radiologic monitoring as evidenced below: a. December 22, 2008 - CT Scan - (Results) (1) 9 mm geographic lytic lesion in the C6 vertebral body, which was not within the field of view on the prior examination. (2) Region of focal lucency in the stemum at the level of the first costosternal articulation. While this finding is more conspicuous than on the prior examination, it has internal fat density. Further review of the report of the study on the aforementioned date revealed the most conceming finding was the cervical vertebral body lesion. "The appearance of the scapular lesion suggests that it may not be related to the vertebral body lesion. The vertebral body lesion raises the concem for metastatic disease and myeloma, and recommends further evaluation with nuclear medicine bone scan and myeloma	I 401		

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I 401	Continued From page 5 labs." b. December 31, 2008 - Radiologic examination for further assessment of the "Vertebrae Lesions (back)", (Results) (1) The finding in the right glenoid may represent arthritic/degenerative change, however, the primary bone lesion is also considered. (2) Recommend radiographic correlation of the right glenoid." c. February 11, 2009 - Recall visit for a MRI of Right Scapula to evaluate the scapula lesion. A consultation report revealed a recall visit for a MRI of Right Scapula to evaluate the scapula lesion. The consultation report noted the following information: (1)"Findings of the February 11, 2009 partial study revealed a "Comparison with prior MRI of August 7, 2008 and CT of December 22, 2008 (2) C6 and sternal lesions discussed on the December 22, 2008 were not within the field of the examination, "Unable to do study due to the fact that patient was moving during study. Patient needs sedation." (3) Examination was not performed for the evaluation of the rotator cuff or glenoid labrum. d. February 27, 2009 - Recall visit for a MRI of Right Scapula to evaluate the lesion. (Results) The resident was sedated with Alprazolam 3 mg PO at 2:00 p.m. The consultation report contained a comment, "Patient unable to hold still for MRI." Record review on January 6, 2010, at 4:40 p.m.,	I 401	PCP in reviewing results of CT scan and bone scan recommended further evaluation of lab done on 12/29/08 which ruled out Multiple Myeloma. (see attached) A bone scan evaluation was done on 12/31/08 as recommended (see attached). Findings of all diagnostic and laboratory tests were communicated to the PCP who did not recommend a repeat MRI with sedation, but referred to an Oncologist for further evaluation. (see attached) Nursing team has scheduled appointment for R #1 and will ensure appropriate follow up will take place. Ongoing monitoring will be performed by Nursing team to ensure compliance.	12/29/08 and ongoing 2/28/10 and ongoing

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I 401	Continued From page 6 revealed a physician's order dated March 31, 2009, regarding the February 27, 2009, recall visit for MRI. The order revealed that due to two attempts, one with sedation and one without sedation, the MRI of Rt. Scapula should not be repeated. There was no evidence the facility had developed strategies for monitoring and/or alternatively addressing the abnormal findings described in the client's readiological studies. 3. The GHMRP failed to ensure timely treatment services for the maintenance of dental health for Resident #2. Interview with the LPN on January 6, 2010, at 10:12 a.m. revealed that Resident # 2 had regularly scheduled dental visits. On January 6, 2010, at 10:30 a.m., review of a dental consultation report dated April 13, 2009, revealed the purpose of the visit was to have two cavities filled. It was noted on the report, "Performed one surface composite filling on #11." The resident returned to the dentist on October 28, 2009, and was non-compliant for treatment. Sedation was recommended for the next scheduled appointment. On January 6, 2010, at 3:35 p.m., the record review revealed that the resident returned to the dentist on November 4, 2009. The consultation report, however, did not mention of the second cavity, which was identified by the dentist on April 13, 2009. Interview with the nurse on January 6, 2010 at 3:49 p.m. revealed it could not be confirmed if the second cavity had been filled. At the time of the survey, there was no evidence that the resident had received the recommended	I 401	LPN Case Manager has scheduled dental evaluation for individual #2 for 3/10/10 to query if second cavity was filled. Symbral has increase nursing administrative staff, in the hiring of a RN for ICMR facility with a specific job description of monitoring all medical consultation with concentration on recommendation, diagnosis and treatment provided. LPN Case Manager will monitor monthly, RN and DON will monitor monthly and provide quarterly oversight to ensure compliance.	3/10/10 and ongoing

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I 401	Continued From page 7 preventive treatment for the maintenance of his dental health. 4 The facility failed to ensure that all drugs were administered In compliance with the physician ' s orders for Resident #1. Interview with the licensed practical nurse (LPN) on January 5, 2009, at 3:46 p.m. revealed Resident #1 that Selenium Sulfide 2.5% was prescribed to treat the rash behind his right ear/neck. Record review on January 5, 2010, at 4:03 p.m. revealed a physician's order dated October 19, 2009 for "Selenium Sulfide lotion 2.5%, apply to neck at bed time..." The LPN reported that upon receipt of the cream, the direct care staff were instructed on how and when to apply the medication, and to document each time it was applied. The review of the MAR, however, revealed no documented evidence that the cream was applied to the resident's neck, as prescribed, from October 21, 2009 through October 31, 2009. 5. The facility failed to ensure a comprehensive assessment of the nutritional needs of Residents #1 and #2. a. The facility failed to ensure a comprehensive reassessment of Resident #2's food preferences and the continued need for a nutritional supplement as evidenced below: On January 4, 2010, at 6:05 p.m., Resident #2 received his dinner meal (fish, yellow rice, green beans, pear halves) and 8 ounces of Resource " Breeze " . He drank all of the Resource " Breeze " , however required verbal prompts from staff to eat his meal. At 6:38 p.m., approximately thirty	I 401	LPN Case Manager has conducted training on documentation of topical on 1/14/10. A monitoring tool has been developed. House Manager will monitor documentation daily for the next 90 days. LPN Case Manager will monitor weekly and monthly for the next 90 days (3 months). RN, DON and QMRP will monitor quarterly to provide adherence.	2/1/10 and ongoing

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I 401	Continued From page 8 minutes later, staff asked him if he was finished eating, and the resident gently slapped his own face. He went to the kitchen at 6:44 p.m. and raked approximately 60% of his fish, yellow rice, green beans from the plate into the trash can, but ate most of the fruit. Several minutes later (6:50 p.m.), the licensed practical nurse (LPN) indicated that if the resident was finished eating, he would normally take his plate to the kitchen. Staff indicated that the resident sometimes refused his food, however usually drank 100% of his beverages and ate his dessert. Interview with the staff preparing the meal revealed the resident was prescribed a regular high fiber diet and 8 ounces Resource "Breeze" , one time daily. According to staff, the resident would be offered a snack later that evening. During the day program visit on January 6, 2010, at 12:30 p.m., interview with the day program nurse revealed that staff had reported that Resident #2 was a " picky eater and usually ate his snack, but often put his sandwiches in the trash. On January 6, 2010 at 2:45 p.m., a nursing progress note dated August 18, 2009, revealed the nurse ' s attempts to reach the nutritionist to discuss the possibility of discontinuing the nutritional supplement because Resident #2 was eating 100% of his meals. On January 6, 2010, at 3:10 p.m., review of the resident ' s nutritional assessments at the group home revealed the resident ' s food intake was " usually 75%-100% " . The resident ' s health management care plan dated August 7, 2009, revealed a goal to consume 100% of his food.	I 401	A letter was sent to Nutritionist on 2/26/10 that a reassessment be done for individual #2 to determine if offering him more food of his preferences will maximize intake of diet at meal times copies of letter were sent to Day Program, Social Worker and DDS Service Coordinators follow up response was also be forwarded to ensure best service to individual. QMRP, RN, DON and House Manager will monitor for compliance.	3/10/10 and ongoing

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I 401	Continued From page 9 On January 6, 2010, at 10:33 a.m., review of the annual nutrition assessment dated July 10, 2009, revealed Resident #2 "tolerates consistency. Can be picky at times. Staff says appetite has improved. Likes things like hamburgers, fries milk and peanut butter, and jelly sandwiches. Appetite is 75-100%....estimated kcal needs -1731." A nutrition quarterly report dated October 24, 2009, documented that the resident's regular diet provided 2000 to 2400 calories. At the time of the survey, however,there was no evidence that Resident #2 had been reassessed to determine if offering him more of the preferred foods would maximize intake of the foods in his diet. b. The facility failed to ensure that Resident #1 caloric needs for weight gain to within his desirable weight range were reassessed as evidenced below: During dinner observations on January 4, 2010, at 6:05 p.m., Resident #1 slowly ate 100% of a double portion meal and drank 8 ounces of Ensure Plus. He completed his meal at 6:54 p.m., approximately 50 minutes later. Interview with staff during the dinner meal revealed the resident enjoys his double portions and always consumed 100% of his meals and supplement. Further observation of the resident, however, revealed he appeared to be underweight for his height. Interview on January 4, 2010, at 6:17 p.m. revealed the resident was prescribed a low fat, low cholesterol, chopped, no concentrated diet (double portion for breakfast and dinner) and a p.m. snack. Staff reported that the resident was also prescribed a supplement of Ensure Plus (8 ounces) three times daily to help him gain weight.	I 401	Since survey period individual's weight is 138 lbs (DWR) 135-167 lbs hence individual is within DWR. In addition cross referenced and adopted with I401.1. Nutritional Assessment individual on 1/16/10 and diet to satisfy caloric need.	1/16/10 and ongoing

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I 401	Continued From page 10 Interview with the day program staff on January 2010, at 12:35 p.m. revealed that the Resident #1 was prescribed single portions at lunch and a morning and afternoon snack. During the day program visit, the resident was observed to consume 100% of a single portion diet. During the survey, staff at the day program and the group home agreed that the resident usually consumed 100% of the food and beverages offered. The review of the weight records on January 5, 2010 at 2:15 p.m. revealed the resident had a recommended weight range of 135 to 167 pounds. Further review of the weight chart revealed Resident #1 ' s fluctuating weight from January 2009 (135 pounds) to December 2009 to (133 pounds). On January 6, 2010, at 2:37 p.m., the quarterly nutritional assessment dated October 24, 2009, revealed "Current diet provides 3000 - 3500 calories." The assessment documented that the consumed approximately 75 to 100% of his diet and tolerated his diet well. Although the annual and quarterly nutritional assessments continued to identify weight gain as a goal, the resident achieved no net weight gain from January 2009 to December 2009. At the time of the survey, there was no evidence that the resident ' s caloric need to promote weight had been reassessed by the nutritionist and the interdisciplinary team.	I 401		
I 420	3521.1 HABILITATION AND TRAINING Each GHMRP shall provide habilitation and training to its residents to enable them to acquire and maintain those life skills needed to cope more effectively with the demands of their environments and to achieve their optimum levels	I 420		

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I 420	Continued From page 11 of physical, mental and social functioning. This Statute is not met as evidenced by: Based on observation, interview and record review, the GHMRP failed to failed to provide habilitation and training to enable it residents to acquire and maintain life skills to cope more effectively with the environmental demands of and social functioning of two of the three residing living in the facility. (Residents #1 and #3) The findings include: 1. The facility failed to ensure timely and effective training to encourage wearing of eyeglasses recommended by the interdisciplinary team for Resident #1 as evidenced below: Observation of Resident #1 on January 4, 2010, at 4:50 p.m. revealed he received training on how to count money. He required verbal prompts to correctly state the numbers on the money. Interview with the staff revealed the resident had eye glasses, but did not wear them. Continued interview with staff on January 6, 2010, at 3:50 p.m. revealed Resident #1 required lots of encouragement to put his eye glasses on, and then refused to keep them on for longer than a minute. With encouragement from staff at approximately 5:15 p.m., the resident put on his glasses and looked in the mirror, but refused to keep on the glasses. Staff indicated that the resident was offered his eyeglasses daily at the group home, however did not take them to his day program. Record review on January 6, 2010, at 4:20 p.m. revealed an ophthalmology report dated June 11, 2009 in which the resident was diagnosed with	I 420	Training to encourage individual #2 to wear his eye glasses was don on 1/6/10 and monitoring of the same by staff is being documented daily. QMRP monitors quarterly and House Manager monitors weekly to provide oversight.	1/6/10 and ongoing

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I 420	Continued From page 12 hyperopia and eye glasses were recommended. The individual support (ISP) dated August 3, 2009, included a recommendation that the resident wear his prescribed eye glasses. Although the resident was observed to have the prescribed eye glasses, there was no evidence a structured system had been implemented to increase the resident's tolerance of his eye glasses recommended by the IDT to improve his vision. 2. During the evening observations on January 4, 2010, at 5:40 p.m., Resident #3 was observed responding to staff using short and echolaic sentences. Interview with staff revealed that Resident #3 had a communication device, however was not using it because staff had not been trained on how to use it. Record review on January 5, 2010, at 10:45 a.m., revealed a Speech and Language assessment dated January 31, 2009, documented the resident ' s weaknesses as reduced manual dexterity and a short attention span. A training objective (dated April 8, 2009), using the Basic Talk AAC device was scheduled to be implemented on May 8, 2009. The goal was " to increase communication skills with the use of a low tech electronic AAC device. " Stated training objectives were designed to enable the resident to make requests, to state his name on request, to answer simple questions and to state identifying information. Interview with the QMRP on January 5, 2010, at 9:39 a.m., revealed that the IDT approved the communication goal and that it was to be implement after Resident #3 ' s individual support plan (ISP) which was conducted on April. 8, 2009. Further interview with the QMRP revealed the	I 420	Crossed referenced and adopted with I222.1.	1/9/10 and ongoing

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I 420	Continued From page 13 AAC device was not received until November 2009 that currently staff was awaiting training on how to use the device. On January 5, 2010, at 10:45 a.m., the review of a QMRP note dated June 12, 2009, revealed the AAC device had not been delivered. "Program on hold until delivery of AAC device". Subsequent QMRP progress notes dated July 12, 2009, August 20, 2009, and October 26, 2009 also revealed the AAC device was not available to implement the training objective. At the time of the survey, there was no evidence that the facility had ensured that Resident #3 received continuous active treatment to improve his communication skills.	I 420		